innerVoice
Psychotherapy & Consultation

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Credit/Debit Card* Payment Consent Form

Client Name: _____ _____ _____
Last *First* *Middle*

Credit Card
Billing Address: _____
Street *City* *State* *Zip*

E-mail Address: _____

I authorize billing staff of InnerVoice Psychotherapy & Consultation to charge my card for professional services as follows (please place your initials in the box below):

☐ Recurring charges, not to exceed $_____ per visit†, or any charges not paid by my insurance company‡ within 60 days of charges being incurred; including copays and/coinsurance.

* Due to credit card company restrictions, some payments may not be made using Flex Spending debit cards.
† This amount will be equal to the per-session rate negotiated prior to your first session.
‡ Charges may include deductibles, co-pays, and other non-covered expenses including fees for missed sessions, not to exceed the negotiated rate with your insurance company. ***Please note a cancellation fee of $75 will be charged to the credit card on file the day of the missed appointment if less than a 48 hour notice is provided.***

MasterCard VISA DISCOVER NETWORK

_____ _____ _____ _____

Exp. Date: _____ /_____

CVV #: _____ (3 digits on back of card)

Name on Card: _____ Billing Zip: _____

AMERICAN EXPRESS

_____ _____ _____

Exp. Date: _____ /_____

CVV #: _____ (4 digits on front of card)

Name on Card: _____ Billing Zip: _____

☐ Check here if you would like a credit card receipt e-mailed to you at the e-mail address above.

Card Holder Signature: _____ Date: _____

*Charges will initially appear as Square Inc., and on your credit card statement as SQ*D InnerVoice PC*